MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-a

CERTIFICATE OF DEATH

05608 5

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Hampshire

City or town Okonoko

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Ann Allery

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William Allery

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 3, 1882

8. AGE:

Years	Months	Days	If less than one day
64	4	17	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Jonathan Day

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden name Mary Ann Betton

MOTHER 15. Birthplace West Virginia

16. Informant Ernest Allery

Address Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 23, 1946 (month) (day) (year)

Cemetery or crematory Salem

Location Salem, W. Va.

18. Funeral director Wm. H. McKee

Address Augusta, W. Va.

19. Sept 20, 1946 (Date rec'd by registrar) M. H. Hammond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20-46 19..... at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1- 19 46 to 9-20- 19 46

and that I last saw h.. alive on 9-8- 19 46

Immediate cause of death	DURATION
cancer of the cervix	one year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. Wilson M.D. M. D. or other

Address 59 Green St. Date signed 9-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

08608

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, institution, or street address where death occurred: State Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No.: State Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Henry Anderson

3.(b) Social Security Number: 216-05-5826

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lennie Edith Anderson
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 30 1884

8. AGE: Years 62 | Months 2 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Celanese Corporation

FATHER
12. Name: James Anderson
13. Birthplace: Wales

MOTHER
14. Maiden name: Elizabeth Holaugh
15. Birthplace: Pennsylvania

16. Informant: John H. Anderson
Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 1946 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Westernport, Md

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md

19. Sept 30 1946 (Date rec'd by registrar) Jeannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1946, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h.IM. alive on DEAD Sept 29 1946

Immediate cause of death	DURATION
Intracranial Hemorrhage	at once
Due to: 22 Long rifle bullet in brain	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 9-29-46
Where did injury occur? Lonaconing (City or town) Allegany (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. V. Deming M.D. M. D. or other
Address: Cumberland, Md Date signed: 9/29/46

Deputy Medical Examiner - Allegany Co.

With corrects Baits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08602

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 103 Washington St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Kreugh Nethken Bane

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Isaac H. Bane
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	10	hrs. ..... min.

9. Birthplace: Elk Garden, W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John A. Nethken
13. Birthplace: Oakland, Md.

MOTHER
14. Maiden name: Mary Ann Brandt
15. Birthplace: Elk Garden, W. Va.

16. Informant: Mr. Isaac H. Bane
Address: 103 Washington St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1946 (month) (day) (year)
Cemetery or crematory: Rose Hill Mausleum
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Sept. 3, 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12th 1946 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15th 1946 to Sept 12th 1946 and that I last saw h... alive on Sept 12th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 mos
Due to	
Due to	
Other conditions: Paralysis left side	3 mos

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: C. L. Dineen M.D. M. D. or other
Address: Cumberland Md Date signed 9-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

★ 08603

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 31 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: ~~Frostburg~~ Eckhart
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Johnny Barnes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/22/46

8. AGE: Years | Months | Days: 1½ | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Johnny Barnes
13. Birthplace: Alabama

MOTHER
14. Maiden name: Regina Allen
15. Birthplace: Eckhart Md

16. Informant: Mrs. Johnny Barnes
Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-24-1946 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: Frostburg, Md.

18. Funeral director: Jarbot Parker
Address: Frostburg, Md.

19. 9-24 (Date rec'd by registrar) 19 46 Miss Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 19 46 at 7 00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/22 19 46 to 9/24 19 46
and that I last saw him alive on 9/23 19 46

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please noderline the canse to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Hilda Jewell Kelley M.D.
M. D. or other
Address: Frostburg Md Date signed 9/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

08604

★ Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
147 Hanover St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 147 Hanover St.
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME John Edward Boston

3.(b) Social Security Number 710-09-5610

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Lillian Fisher
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15 1910

8. AGE: Years	Months	Days	If less than one day
36	3	19	..... hrs. ..... min.

9. Birthplace Grafton W. Va.
(Town, county, and state)
10. Usual occupation Porter
11. Industry or business B & O Ry.
FATHER 12. Name John Henry Boston
13. Birthplace Grafton W. Va.
MOTHER 14. Maiden name Leona Brown
15. Birthplace Romney W. Va.
16. Informant Mrs. Lillian Boston
Address Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 6 '46 (month) (day) (year)
Cemetery or crematory National Cem.
Location Grafton W. Va.
18. Funeral director Louis Stein Sons
Address Cumberland
19. Sept 4 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 1:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.[illegible] alive dead Sept 4 1946
Immediate cause of death — DURATION

Cardiac dilatation — at once

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. M. D. or other
Address Cumberland Md. Date signed 9/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124a)

08605

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs.
Hospital, institution, or street address where death occurred: 306 Mountain View drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Mountain View Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Melvin Brant

3.(b) Social Security Number 214-05-7842

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Nettie Crawford
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 10 1903

8. AGE: Years	Months	Days	If less than one day
43	7	22	... hrs. ... min.

9. Birthplace Cumberland Md
(Town, county, and state)
10. Usual occupation Restaurant Prop.
11. Industry or business
FATHER 12. Name D H Brant
13. Birthplace Md
MOTHER 14. Maiden name Lucy Lydinger
15. Birthplace Md.
16. Informant Nettie C Brant
Address Cumberland
17. Burial Date thereof Sept. 5 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hillcrest Cem.
Location Cumberland Md
18. Funeral director Louis Stein Inc
Address Cumberland Md.
19. Sept. 4, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1946, at 7:45 P M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1946, to Sept 2 1946
and that I last saw h— alive on September 1 1946

Immediate cause of death	DURATION
fatal hemorrhage from varicose esophageal veins	3 days
Due to liver cirrhosis	2 years
Due to chronic alcoholism	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M.D.
M. D. or other
Address [illegible] Date signed 9-3-46

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

08607

Reg. Dist. No. 4/

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74. Years

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414. Hill Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Norman W. Brant

3.(b) Social Security Number: 705-09-9985

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Villetta Brant

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): March 28 1872

8. AGE: Years	Months	Days	If less than one day
74	5	20	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: Leonard Brant
13. Birthplace: Hazen, Pa

MOTHER
14. Maiden name: Nancy Rice
15. Birthplace: Hazen Pa

16. Informant: Mrs. Pauline Kenney

Address: 414. Hill St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/46 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 20, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/15/46, 19..., at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/13/46, 19..., to 9/15/46, and that I last saw him alive on 9/16/46, 19...

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. Gilliam M.D.
M. D. or other

Address: Med. Bldg. Date signed: 9/19/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08606

1454

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 Yrs 3 Mo 7 Days

Hospital, institution, or street address where death occurred:
707. Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 707. Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca Ildred Brubaker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William A. Brubaker

8.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): June 7 1879

8. AGE: Years	Months	Days	If less than one day
67	3	20	..... hrs. ..... min.

8. Birthplace: Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: John B. Pitzer
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Jane Rebecca Byroad
15. Birthplace: Cumberland, Md.

18. Informant: William A. Brubaker
Address: 707. Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/29/46 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept 28 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1946, at 11 m. A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-23-1938 to 9-27-1946 and that I last saw h. alive on 9-26-1946

Immediate cause of death: Chronic Myocardial Degeneration

DURATION

Due to:

Due to:

Other conditions: Paracentesis 75 times.
(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jno. F. Weimer M. D. or other

Address: Cumberland Date signed: 9-28-46

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08608

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 Years

Hospital, institution, or street address where death occurred: 39. Lamont St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 39. Lamont St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Phillip Butler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 25 1887

8. AGE: Years	Months	Days	If less than one day
59	6	17	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Retired Tin Mill Employee

11. Industry or business: N. G. Taylor Co

FATHER
12. Name: George Butler
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Laura Showacre
15. Birthplace: Oldtown, Md.

16. Informant: Miss Clara E. Butler

Address: 39. Lamont St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/15/46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 14 1946. (Date rec'd by registrar) Jos. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1946, at about 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h/m alive on dead Sept 12 1946

Immediate cause of death	DURATION
Acute dilatation of the heart	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. V. Deming M.D.
M. D. or other

Address: Cumberland 2nd Date signed 9-13-46.

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

★ 08609

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Eckhart Mines Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Charles Carter

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nellie Conner

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Mar 18th 1876

8. AGE: Years 70 | Months 6 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace Eckhart Mines, Md.
(Town, county, and state)

10. Usual occupation Storekeeper

11. Industry or business Grocery

FATHER
12. Name Henry Carter
13. Birthplace Eckhart Md.

MOTHER
14. Maiden name Marian Carter
15. Birthplace Eckhart, Md.

16. Informant Mrs. Esther Carter
Address Eckhart Mines, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-1946 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart Md.

18. Funeral director Jacob Kaye

Address Frostburg, Md.

19. 9-26 1946 Mrs. Nancy N. Kaye
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1946 at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 26 1946 and that I last saw him alive on Sept 26 1946

Immediate cause of death	DURATION
C-V-Renal Disease	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Gattens M.D.
M. D. or other

Address Frostburg, Md. Date signed 9/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08610

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 330½ Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jerriett W. Cassen Jr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febuary I4, I884

8. AGE: Years	Months	Days	If less than one day
62	6	27	..... hrs. ..... min.

9. Birthplace: Cumberland, Md
(Town, county, and state)
10. Usual occupation: Fireman And Laborer
11. Industry or business
FATHER 12. Name: Jerriett W. Cassen
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Ella Hoenicka
MOTHER 15. Birthplace: Maryland
16. Informant: Cristopher Cassen
Address: 55I Machanic St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. I4, I946 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.
19. Sept. 17, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-11-1946, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-23-1946 to 9-11-1946
and that I last saw h... alive on 9-11-1946

	DURATION
Immediate cause of death: Cancer of the rectum	One year
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: Cancer of the rectum
Date of op. 9-3-46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: L. Weiss M.D. (M. D. or other)
Address: 59 Greene St. Date signed: 9-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

C8611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Miners hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: R.D 2 Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: James Clark

3. (b) Social Security Number: 217-01-7229

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Pearl Clark

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): February 12 1897

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	7	0		

9. Birthplace: Swigel Garrett Cty., Md.
(Town, county, and state)

10. Usual occupation: miner

11. Industry or business: clay mines

FATHER — 12. Name: John Clark

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Hally Swinbreener

MOTHER — 15. Birthplace: Maryland

16. Informant: James Clark Jr.

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14 1946 (month) (day) (year)

Cemetery or crematory: Jolliffe Cemetery

Location: Garrett Co., Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. 9-12 1946 Mrs. Lallie V. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1946; at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Sept 11 1946

and that I last saw him alive on Sept 11 1946

Immediate cause of death: Chronic Myocarditis — DURATION: several years

Due to: Cerebral Embolism — 1 mo

Due to: Left Hemiplegia — 1 mo

Other conditions: Terminal Bronchial Pneumonia — 3 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D.
M. D. or other

Address: Frostburg Md Date signed: Sept 12 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits R WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

08612

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY CO. Memoral Hospital
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 DAYS
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 72 PERSHING ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MR JAMES P. CONWAY
3. (b) Social Security Number 097 01 5225 N.Y

4. Sex MALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife ALICE GILLESPIE
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) June 8 1901

8. AGE: Years	Months	Days	If less than one day
45	3	16	hrs. min.

9. Birthplace MD. CUMBERLAND, ALLEGANY CO. (Town, county, and state)
10. Usual occupation TIME STUDY ENGINEER
11. Industry or business

FATHER
12. Name JOHN CONWAY
13. Birthplace PA.

MOTHER
14. Maiden name ETTA BOOKER
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1946 (month) (day) (year)
Cemetery or crematory Body stored in
Location Rose Hill Mausoleum will be removed to [illegible] New York
18. Funeral director John C. Wolford
Address Cumberland, Md
19. Sept 26 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 24 1946 at 5:56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 21, 1946 to Sept. 24, 1946
and that I last saw him alive on Sept. 23, 1946

Immediate cause of death Late Cancer Stomach, Pancreas, Mid Colon — DURATION: 6 Months
Due to Primary carcinoma of stomach
Due to Excision for Emergency relief
Other conditions metastases to pancreas, colon and liver.
(Include pregnancy within 3 months of death)
Major findings of operation Excision
Date of op. Sept 23 46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M.D. or other
Address Date signed

(I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

08613

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 106 Oak St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Oak St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth May Cornwell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry L Cornwell

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 7 1878

8. AGE: Years: 68 | Months: 4 | Days: 18 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER

12. Name: Ambrose St Morris

13. Birthplace: Lynchburg Va

MOTHER

14. Maiden name: Sarah Knippenberg

15. Birthplace: Md.

16. Informant: Ruth E Cornwell

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 28 46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Long Stein Inc

Address: Cumberland

19. Sept 28, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 19 46 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 19 46 to Sept 25 19 46 and that I last saw her alive on Sept 25, 46 19 ____

Immediate cause of death	DURATION
Carcinoma breast	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: R H Williams, M.D. M. D. or other

Address: Md Bldg Date signed: 9/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

C8614

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, lastitution, or street address where death occurred:

How long la hospital or lastitutioa?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Beale St

(If rural, give LOCATION)

2.(a) If veteraa, aame war

3.(a) FULL NAME Orrin Nathaniel Crosby

3.(b) Social Security Number 214-01-3684

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nellie Crosby

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) October 12 1901

8. AGE: Years 44 | Months 10 | Days 21 | If less than one day ... hrs. ... min.

8. Birthplace Frostburg Allegany Md.
(Town, county, and state)

10. Usual occupation Miner

11. Iadustry or business Coal mines

FATHER 12. Name John Crosby

13. Birthplace Frostburg Md.

MOTHER 14. Maidea name Eva Hartzog

15. Birthplace Frostburg Md.

16. Iaformant John Crosby

Address Frostburg Md.

17. Burial Date thereof Sept. 5 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director J. J. Durst

Address Frostburg Md

19. 9-4 1946 Mrs. Hattie N. Doe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1946, at 3 30 A. M

21. I CERTIFY that death occurred oa the date above stated; that I atteaded deceased from ... 19... to ... 19...

and that I last saw h... alive Sept 3 1946

Immediate cause of death	DURATION
Coronary occulusion	at once
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major fiadings of operations

Date of op.

Aotopsy results

PHYSICIAN: Please uaderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill ia the followiag:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, ladustry, public place (where?)

Meaas of injury Injured at work?

23. SIGNATURE N. V. Deming M.D.
M. D. or other

Address Date signed 9/3/46

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

Dr. Lobb Bring?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

C8615

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

Collins Nursing Home - 7 Virginia Ave.

How long in hospital or institution? 1 year 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 801 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Golda Henrietta "Stump" Darr

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife James E. Darr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17, 1888

8. AGE:	Years	Months	Days	If less than one day
	58	2	20	..... hrs. ..... min.

9. Birthplace Romney, Hampshire, W.Va.
(Town, county, and state)

10. Usual occupation Manager & owner

11. Industry or business Employment Agency

FATHER
12. Name Samuel D. Stump
13. Birthplace Stonesville, W.Va.

MOTHER
14. Maiden name Edith V. Powers
15. Birthplace Ohio

16. Informant Mrs. Mildred Fretwell

Address 304 Furnace St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1946 (month) (day) (year)

Cemetery or crematory Little Capon Cemetery

Location Near Levels, W.Va.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Sept. 9 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Sept. 7 1946 and that I last saw h.. alive on September 2 1946

Immediate cause of death	OURATION
Cysto-pyelitis	3 months
Due to nuyelitis	3 yrs.
Due to pernicious anemia	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. Wiles M.D. M. D. or other

Address 59 Greene St. Date signed 9-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8616

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: 21st Bridge -near McCoole, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: 21st Bridge - Near McCoole, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Abraham Dayton

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Annie Whitehare Dayton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	23	hrs. min.

9. Birthplace: Mineral Co., W. Va.
(Town, county, and state)

10. Usual occupation: Retired - B. & O. Ry.

11. Industry or business: Trackman

FATHER
12. Name: Issaih Dayton
13. Birthplace: Mineral Co., W. Va.

MOTHER
14. Maiden name: Do not know
15. Birthplace

16. Informant: E. E. Dayton

Address: Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/1946 (month) (day) (year)

Cemetery or ~~Crematory~~: Dayton Cemetery

Location: 21st Bridge, Md.

19. Funeral director: B. W. Markwood

Address: Keyser, W. Va.

19 Sep 27 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25, 1946 at 8:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30- 1946, to Sept 25 1946 and that I last saw h... alive on Sept 24 1946.

Immediate cause of death	DURATION
Carcinoma Prostate	10 months
Due to	
Due to	
Other conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: I C Griffin MD M. D. or other

Address: Keyser W Va Date signed 9-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-B

CERTIFICATE OF DEATH

08617

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred: Main Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Patrick Doolan

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine McHugh Dolan

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 27, 1881

8. AGE:

Years	Months	Days	If less than one day
65	7	9	...hrs. ...min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Hotel Proprietor

11. Industry or business: Hotel

FATHER
12. Name: Dennis Doolan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Anna Murray
15. Birthplace: Ireland

16. Informant: Mrs. Edward Atkinson
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 9, 1946 (month) (day) (year)

Cemetery or crematory: St. Marys Cemetery

Location: Lonaconing, Md.

18. Funeral director: Dr. Eichhorn

Address: Lonaconing, Md.

19. Sept 7 1946 (Date rec'd by registrar) Jannette M. Beal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~June~~ Sept. 6 1946, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 1946, to Sept. 6 1946 and that I last saw him alive on Sept 5 1946

Immediate cause of death	DURATION
Carcinoma of prostate	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: Henry G. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed: Sept 7 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

Dr. Vale

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 08618 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Memorial Hosp.

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 DAVIDSON S.T.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MARY A DUCKWORTH

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) DEC. 22 1868

8. AGE: Years	Months	Days	If less than one day
77	8	15	... hrs. ... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business Housewife

FATHER
12. Name GEORGE DUCKWORTH
13. Birthplace ENGLAND

MOTHER
14. Maiden name HELEN
15. Birthplace Unknown

16. Informant Mrs Hazel Harney
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10, 1946 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Sept. 9, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 7 1946 at 12:10 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46, to Sept 7 19 46

and that I last saw h... alive on 7 Sept. 46 19...

Immediate cause of death	DURATION
Squamous Cell Epithelioma of Left Cheek with Generalized	15 yrs
Due to Metastasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None.

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Vale Owens, M.D. M. D. or other

Address 110 S. Centre St. City Date signed 7 Sept. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DRS HODGES &COWHERD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

C8619 4

Reg. Dist. No.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 30 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County GARRETT
City or town GRANTSVILLE, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anita Fay ~~BABY GIRL~~ FERRELL Twin #2

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 11, 1946

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
		29		

8. Birthplace ALLEGANY, CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name THOMAS FERRELL
13. Birthplace MD.

MOTHER
14. Maiden name MELBA MILLER
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof 9-10-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory grantsville
Location grantsville Md

18. Funeral director Wm Winterberg
Address grantsville Md

19. Sept. 10, 1946. J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 10 1946, at 2:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 1946 to Sept-10 1946
and that I last saw h... alive on Sept. 9 1946

Immediate cause(s) of death	DURATION
(a) Infancy anemia	
Due to (b) Prematurity	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Pryce Hodges, M.D.
M. D. or other
Address Cumberland, Md. Date signed 9/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. J. K. COWHERD
DR. R. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08620

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town GRANTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sheila Kay FERRELL, ~~BABY GIRL~~ NO. I - Twin (PREMATURE)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 11, 1946

8. AGE: Years	Months	Days	If less than one day
		29	hrs. min.

9. Birthplace Memorial Hospital Alleg. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name THOMAS FERRELL
13. Birthplace MD.

MOTHER
14. Maiden name MELBA MILLER
15. Birthplace MD.

16. Informant Tom Ferrell
Address Grantsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-10-1946 (month) (day) (year)

Cemetery or crematory Grantsville

Location Grantsville Md

18. Funeral director Wm Winterberg

Address Grantsville Md

19. Sept. 10, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 10, 1946 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1946 to Sept 10 1946 and that I last saw h[illegible] alive on Sept 10 1946

Immediate cause of death	DURATION
Due to Prematurity.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Royce Hodges M.D.
(M.D., C.D., or other)

Address Cumberland Md Date signed 9/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

086219
Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 38 Centennial St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 38 Centennial St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Leroy Finzel

3.(b) Social Security Number: 577-09-3283

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Genevieve Finzel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1898

8. AGE: Years	Months	Days	If less than one day
48	6	0	hrs. min.

9. Birthplace: Finzel Garrett Cty. Md. (Town, county, and state)
10. Usual occupation: Employed in Dye House
11. Industry or business: Celanese Corp.

FATHER
12. Name: William Finzel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Bolden
15. Birthplace: Maryland

16. Informant: William Finzel
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21 1946 (month) (day) (year)
Cemetery or crematory: Finzel Cemetery
Location: Finzel, Md.

18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 9-20 1946 Mrs. Haney N. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1946 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1946 to September 18 1946; and that I last saw him alive on September 18 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	5 minutes
Due to: Hypertension.	6-9 mos.
Due to: Secondary anemia	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl M.D. M. D. or other
Address: Frostburg, Md. Date signed: 9/20/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

Dr. R. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

68622

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Maple Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Margaret Fisher

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Leroy Fisher

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) February 2, 1879

8. AGE: Years	Months	Days	If less than one day
67	7	22	...hrs. ...min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name John Reuschel
13. Birthplace Germany

MOTHER
14. Maiden name Hartung, Anna
15. Birthplace Gemany

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27, 1946 (month) (day) (year)

Cemetery or crematory Hillcrest

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Sept. 25 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1946, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2, '46 1946, to Sept. 24 1946

and that I last saw her alive on Sept 24, '46 1946

Immediate cause of death	DURATION
Chronic Nephritis	
Due to Arteriosclerosis	
Due to	
Other conditions Bronchopneumonia & Cancer of Breast	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. J. Williams, M.D.
M. D. or other

Address Med. Bldg. Date signed 9/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08623

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
316 Pulaski St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 316 Pulaski St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: August H. Fogtman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Brochey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug, 21, 1856

8. AGE: Years	Months	Days	If less than one day
90	0	22	....hrs. ....min.

9. Birthplace: Cumberland, Md
(Town, county, and state)
10. Usual occupation: Retired Contractor
11. Industry or business
FATHER 12. Name: Henry Fogtman
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary Ann Bush
15. Birthplace: Germany
16. Informant: Mrs. Mary Leasure
Address: 316 Pulaski, St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 16, 1946 (month) (day) (year)
Cemetery or crematory: St. Peter & Paul Ceme.
Location: Cumberland, Md
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.
19. Sept 15 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1946 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 1946, to 9-13- 1946
and that I last saw h alive on 9-3- 1946

	DURATION
Immediate cause of death: Chronic myocardial d	6 months
Due to: Arteriosclerosis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other
Address: 59 Green St. Date signed 9-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

08624

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 Klosterman's Addt.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Michael Copeland Gilliand

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4, 1944

8. AGE:	Years	Months	Days	If less than one day
	2	7	22	hrs. min.

9. Birthplace: Cumberland, Md (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business
FATHER 12. Name: Leslie Gilliand
13. Birthplace: Parkersburg, W.Va.
MOTHER 14. Maiden name: Mabel M. Copeland
15. Birthplace: Parkersburg, W.Va.
16. Informant: Leslie Gilliand
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 28, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cemetery
Location: Parkersburg, W.Va.
18. Funeral director: John J. Hafer
Address: Cumberland, Md.
19. Sept 26, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-26 1946, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1946, to 9-26 1946
and that I last saw h alive on 9-25 1946

	DURATION
Immediate cause of death: pulmonary edema	min.
Due to: cardiac failure	months
Due to: chronic nephritis	many years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: contracted kidneys
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L Blum M.D. M. D. or other
Address: 59 Greene St. Date signed: 9-26-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

Within corporate limits ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

CERTIFICATE OF DEATH

U8625

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Co. Infirmary

How long in hospital or institution? Nov 30, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 Columbia ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lucinda Gordan

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife Henry Gordon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	9	..... hrs. ..... min.

9. Birthplace Emmerson Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Markle

13. Birthplace Pa

MOTHER 14. Maiden name Sarah Unknown

15. Birthplace "

16. Informant Mrs Walter Hardman

Address 610 Columbia Ave.

17. Burial Date thereof Sept 8, 1946
(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Odd Fellows Cem.

Location Frostburg, Md

18. Funeral director Louis Stein Son

Address Cumberland, Md

19. Sept 7 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30 1945 to Sept 5 1946 and that I last saw h.. alive on Sept 4 1946

Immediate cause of death	DURATION
Hemiplegia	
Due to Generalized Arteriosclerosis	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. J. Williams M.D. or other

Address Cumberland Date signed 9-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 76

CERTIFICATE OF DEATH

Reg. Dist. No. 8 — 08626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Allegany
City or town: R.DI Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Barton R.D.I
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Alexander Green

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Elizabeth Green
June 3 - 1864 6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.): Febuary 22- I866

8. AGE: Years	Months	Days	If less than one day
80	7	8	hrs. min.

9. Birthplace: R.D.I Barton Md Allegany Co.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Robert Green
13. Birthplace: Not Knowen

MOTHER
14. Maiden name: Sara Green
15. Birthplace: R.D.2 Grantsville Md

16. Informant: Fred E Green
Address: Luke - md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 3, I946 (month) (day) (year)
Cemetery or crematory: Laurel Hill
Location: R.D.I Barton Md
18. Funeral director: Wm Altimus Berg
Address: Grantsville Md
19. Oct 4 19 46 (Date rec'd by registrar) Jannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 19 46 at 10:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 19 46 to Sept. 30 19 46
and that I last saw h... I... alive on Sept. 30 19 46

Immediate cause of death	DURATION
Aneurysm of Abdominal Aorta	10 Years
Due to: Spontaneous Rupture of Abdominal Aorta	Few minutes
Due to:	
Other conditions: Hypertrophy of Prostate	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophy of Prostate and Aortic Aneurysm Date of op. Mar. 15. 1946
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul A Wilson M.D.
M. D. or other
Address: Piedmont W. Va. Date signed Oct. 2, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (700)

CERTIFICATE OF DEATH

Reg. Dist. No. 0809 — 08827

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Miners hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: Patrick Joseph Grimes

3.(b) Social Security Number: 177-09-4294

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 2, 1902

8. AGE: Years	Months	Days	If less than one day
44	3	21	...hrs. ...min.

9. Birthplace: Midland, Allegany Cty., Md. (Town, county, and state)
10. Usual occupation: Rayon worker
11. Industry or business: Celanese Corporation
FATHER 12. Name: John Grimes,
13. Birthplace: Maryland
MOTHER 14. Maiden name: Anna Goodwin,
15. Birthplace: Maryland
16. Informant: John Grimes,
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 26 '46 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery, Frostburg, Md.
Location
18. Funeral director: J. R. Durst.
Address: Frostburg, Md.
19. 9-25-46 (Date rec'd by registrar) Mrs Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23 1946 at 5.05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on Sept 23 1946
Immediate cause of death: Pulmonary Embolism — DURATION: about 44 hrs
Due to: Fracture of lower left leg
Due to:
Other conditions: Crushed chest & contusion of brain
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9.21-46
Where did injury occur? Frostburg (City or town) Allegany (County) Md. (State)
Injured at home, farm, Industry, public place (where?): Route 36 foot of Grant St.
Means of injury: Hit by auto. Injured at work? no

23. SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. M. D. or other
Address: Cumberland, Md. Date signed: 9-24-1946
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1225a)

CERTIFICATE OF DEATH

08628

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Allegany Hospital - Cumberland, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 789 Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Belle Hambright

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife: J[illegible] 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 16, 1855

8. AGE: Years: 91 Months: 7 Days: 21 If less than one day: hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Emanuel Hambright
13. Birthplace: Lancaster, Pa.

MOTHER
14. Maiden name: Julia Blocher
15. Birthplace: Cumberland, Md.

16. Informant: Allegany Hospital
Address: 215 Decatur St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 9, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 9, 1946. (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION 12:08

20. DATE OF DEATH: September 7, 1946, at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29th 1946 to Sept. 6 1946.

and that I last saw h[illegible] alive on Sept. 6th 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	9 days
Hemiplegia (Left).	
Due to	
Due to	
Other conditions: Hypertension - Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James E. McLean M.D. M. D. or other

Address: 149 Greene St. Date signed: 9-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08629

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

116 S. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 So. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war First World War

3.(a) FULL NAME William Joseph Harbaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13 ~~1946~~ 1895

8. AGE:

Years	Months	Days	If less than one day
51	6	12	hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Book Store

FATHER

12. Name L.Frank Harbaugh

13. Birthplace Pa.

MOTHER

14. Maiden name Martha E.Hickey

15. Birthplace Pa.

18. Informant M.Ella Harbaugh

Address 116 S.Mechanic St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27 1946 (month) (day) (year)

Cemetery or crematory St P.& P. Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Sept. 26, 1946 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 19 46, at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Sept. 25 19 46

Immediate cause of death	DURATION
Angina Pectoris	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.V.Deming M.D. H.V.Deming M.D. M. D. or other

Address Cumberland Md. Date signed 9-26-46

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

08630

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Knapps Meadow (If outside city or town limits, write RURAL and give nearest town) Lonaconing
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Knapps Meadow near Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: John Jacob Hauserath

3.(b) Social Security Number: 217-03-2167

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Fair Hauserath
6.(c) If alive, give age: 31 years
7. Birth date of deceased (mo., day, yr.): Aug 30, 1895

8. AGE:

Years	Months	Days	If less than one day
51	0	29	... hrs. ... min.

9. Birthplace: Frostburg Allegany Co., Md. (town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business: George's Creek Coal Mining Co.
12. Name of FATHER: George Hauserath
13. Birthplace of FATHER: Germany
14. Maiden name of MOTHER: Mary L. Adlpert
15. Birthplace of MOTHER: Frostburg, Md
16. Informant: Mrs. Catherine Hauserath
Address: Knapps Meadow near Lonaconing
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 1 1946 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md
19. Oct 1 1946 (Date rec'd by registrar) Jeanette M. Broil Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 1946 at 4 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21st 1946, to Sept 29 1946
and that I last saw him alive on Sept 29 1946

Immediate cause of death	DURATION
Failure of heart due to	
Acute Dilatation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Henry Dr. Hodgson by he M. D. or other
Address: Lonaconing Md Date signed Oct 1st 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08631

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, Institution, or street address where death occurred: 407 Furnace St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 407 Furnace St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Bertha L. Henkel

3.(b) Social Security Number: 214-05-6949

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec 3 1890

8. AGE: Years	Months	Days	If less than one day
55	9	23	...hrs. ...min.

9. Birthplace: Inc Keyport Pa.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Hospital Employee

FATHER — 12. Name: Carl Henkel

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Henrietta Grantz

MOTHER — 15. Birthplace: Md.

16. Informant: Albert Henkel

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28, 1946 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Sept 28, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 1946, at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw her ER Dead Sept 26 1946

Immediate cause of death	DURATION
Acute dilatation of the heart	5 min
Due to: Acute indigestion	about ½ hr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 9/26/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits X

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 4

08632

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital - Cumberland, Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 Paca St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. John Hext

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1863

8. AGE: Years	Months	Days	If less than one day
82	8	10	..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Meat Cutter

11. Industry or business: Retired

FATHER
12. Name: William Hext
13. Birthplace: England

MOTHER
14. Maiden name: Eleanor Corley
15. Birthplace: Penna.

16. Informant: Allegany Hospital
Address: 215 Decatur St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1946 (month) (day) (year)

Cemetery or crematory: St. Lukes Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Sept 9 1946 (Date rec'd by registrar) Joseph D. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1946 at 11:17 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Aug. 1946 to 7 Sept. 1946 and that I last saw h[illegible] alive on 7 Sept. 46 1946

Immediate cause of death	DURATION
Intestinal obstruction,	6 weeks
Due to Chronic, small bowel,	
Cause indetermined.	
Due to Cancer of intestine. Cuba.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none done

Date of op.

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Alfred Vaccaro M. D. or other

Address: 110 S. Centre St. Date signed: 8 Sept 46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

08633

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Pear St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna L. Higgins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 30, 1863

8. AGE:	Years	Months	Days	If less than one day
	82	II	I6	..... hrs. ..... min.

9. Birthplace Vale Summit, Md.
(Town, county, and state)

10. Usual occupation Railroad, Emp. - Retired

11. Industry or business

FATHER 12. Name Patrick Higgins

13. Birthplace Ireland

MOTHER 14. Maiden name Margaret Powers

15. Birthplace Ireland

16. Informant Allegany Hospital

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18, 1946 (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. Sept. 17, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1946, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/18/46 19.., to 9/16 19.46 and that I last saw h.. alive on 9/16/46 19..

Immediate cause of death: Coronary Occlusion. (Heart)

DURATION

Due to

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Rozum M.D. M. D. or other

Address Cumberland, Md. Date signed 9/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 08634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Holder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A. Beveridge Holder

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug. 12 1878

8. AGE: Years: 68 Months: 1 Days: 8 If less than one day: hrs. min.

9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)

10. Usual occupation: at Coal Mines

11. Industry or business: Mine No 8 (Consol)

MOTHER FATHER 12. Name: Albert T. Holder

13. Birthplace: England

MOTHER 14. Maiden name: Agnes Bowden

15. Birthplace: England

16. Informant: Mrs. Pete Briner

Address: Midland, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Sept 23 1946 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md.

19. Sept. 21, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1946, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1942, to September 20 1946

and that I last saw h— alive on September 20 1946

	DURATION
Immediate cause of death: Congestive heart failure	2 years
Due to: Chronic myocarditis	4 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Briner M.D. M. D. or other

Address: 59 Greene St. Date signed: 9-21-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 08685 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or Institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgely
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Bridge St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Arch Leroy Huffman

3. (b) Social Security Number: 705-07-9637

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ida Costello Huffman

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): January 10, 1890

8. AGE: Years	Months	Days	If less than one day
56	8	18	hrs. min.

9. Birthplace: Staunton, Va.
(Town, county, and state)

10. Usual occupation: Blacksmith helper.

11. Industry or business: B & O RR - Bolt & forge shop.

FATHER
12. Name: Minor Huffman
13. Birthplace: Mt. Sidney, Va.

MOTHER
14. Maiden name: Ott
15. Birthplace: Va.

16. Informant: Ruth Rowe

Address: 425 Henderson Ave., Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 1, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Harper

Address: Cumberland, Md.

19. Oct. 1, 1946 (Date rec'd by registrar) J. L. Franklin, M.D., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17th 1946, to Sept. 28th 1946; and that I last saw h[illegible] alive on Sept. 28 1946

Immediate cause of death	DURATION
(a) Coronary Thrombosis	7
Due to:	
Due to:	
Other conditions: Hypertension; Chronic Myocarditis	? ?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. E. Mahan M.D. M. D. or other

Address: 49 Greene St. Date signed: 9/30/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

Dr. Tolson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 98 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: P. O. Box 145, Willowbrook Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mr. Theodore Johnson

3.(b) Social Security Number
213-22-4119

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda Hanking

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 26, ~~1875~~ 1871

8. AGE:	Years	Months	Days	If less than one day
	~~75~~ 75	4	20	hrs. min.

9. Birthplace: Pennsylvania, Somerset Co.
(Town, county, and state)

10. Usual occupation: Unable to work

11. Industry or business

FATHER
12. Name: Ruben Johnson
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Pinkerton
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18, 1946 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John F. Hofer

Address: Cumberland, Md.

19. Sept. 18 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6-10- 1946 to 9-16- 1946 and that I last saw him alive on 9-16- 46 1946

Immediate cause of death: Carcinoma bladder — DURATION: about 1 year

Due to:

Due to:

Other conditions: arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: Carcinoma bladder - infiltrating

PHYSICIAN: Please underline the cause to which death is to be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard L. Tolson M.D. M. D. or other

Address: Cumberland Md. Date signed 9-16-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 08637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~Lifetime~~ 45 years

Hospital, Institution, or street address where death occurred:
Wineow St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Green St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William H. Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Flora B. Shank

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): June 24, 1895

8. AGE: Years	Months	Days	If less than one day
51	2	15	...hrs. ...min.

9. Birthplace: Artemas, Bedford Co, Pa.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Own truck

FATHER
12. Name: John Johnson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs. William H. Johnson

Address: 506 Greene St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 12 1946 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hoffman

Address: Cumberland, Md.

19. Sept. 12 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 19 46 at about 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on Sept 10 19 46

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 9-10-46

Deputy Medical Examiner - Allegany Co.

Within co...

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-a)

CERTIFICATE OF DEATH

08638 Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. #5 - Box 302 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Kathleen E. Jones

3. (b) Social Security Number None

4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife James Jones

~~January 12, 1909~~ 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) January 12, 1909

8. AGE: Years 37 Months 7 Days 24 If less than one day ... hrs. ... min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business Housewife

FATHER 12. Name Gilbert Haines

13. Birthplace W. Va.

MOTHER 14. Maiden name Olive Haines

15. Birthplace W. Va.

16. Informant Allegany Hospital

Address 215 Decatur St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1946 (month) (day) (year)

Cemetery or crematory St Marys Cem.

Location Old Town Rd.

18. Funeral director Louis Stern Inc.

Address Cumberland Md.

19 Sept. 7, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1946, at 4:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-8 1942, to 9/6 1946

and that I last saw her alive on 9/6 1946

	DURATION
Immediate cause of death: pulmonary embolism	1/2 hour
Due to: after salpingo-oophorectomy hysterectomy	24 hours
Due to: [illegible]	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations [illegible]

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE [illegible] M.D. (M. D. or other)

Address [illegible] Date signed 9-7-46

Outside of City limits

Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

★ 08639 Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Williams Rd R.F.D. #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Williams Rd R.F.D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Jones

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife Harry Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1879

8. AGE: Years 67 | Months 11 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Hampshire Co West Va
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Elisha D. Nolan

13. Birthplace West Va

MOTHER 14. Maiden name Amanda Zilen

15. Birthplace West Va.

16. Informant Mrs Chas. McCulley

Address Williams Rd R.F.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1946 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland

18. Funeral director Louis Steiner Inc

Address Cumberland

19. Sept. 7 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 5 1946 to September 5 1946 and that I last saw h[illegible] alive on September 5 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage right side	6 hours
Due to Arteriosclerosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Z. Johnson Jr. M.D.
M. D. or other

Address Cumberland Md Date signed 9-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08640

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 WEEKS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 503 CUMBERLAND Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JUDENBERG, MAX MR.

3.(b) Social Security Number None

4. Sex	5. Color of race	6.(a) Single, married, widowed, or divorced
MALE	W	Widowed

6.(b) Name of husband or wife Minna Rosenberg Judenberg 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1876

8. AGE: Years	Months	Days	If less than one day
69	9	14	... hrs. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name JUDENBERG, LESER
13. Birthplace GERMANY

MOTHER
14. Maiden name ROSENBERG, MINA
15. Birthplace GERMANY

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30, 1946 (month) (day) (year)
Cemetery or crematory East View
Location Cumberland, Md.
18. Funeral director Charles L. George
Address Cumberland, Md.

19. Sept. 30 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 - 1946, at 12 N. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1946, to Sept 28 1946
and that I last saw h[illegible] alive on Sept 28 1946

	Interval between onset and death
Immediate cause of death Coronary Hypertension Cardio vascular Renal D.	1 Duration yrs
Due to Mitral Stenosis + Insufficiency	6 yrs + ?
Due to	
Other conditions Hypertrophic Prostatitis?	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Russell Jacobson M. D. or other
Address 153 Lee St Date signed 9-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

★ 08641

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:
Brant Road near Cresaptown

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ★ World War I

3.(a) FULL NAME Vernon R. Keafer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1891

8. AGE: Years	Months	Days	If less than one day
55	1	2	hrs. min.

9. Birthplace Midland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own farm

FATHER 12. Name August Keafer

FATHER 13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Olive Poland

MOTHER 15. Birthplace Lord, Md.

16. Informant Lawrence Strickland

Address Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 23, 1946 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Maryland

18. Funeral director John T. Hafer

Address Cumberland, Md.

19. 9/23/46 (Date rec'd by registrar) M. M. Wannacutt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 19 46 at 7.30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him Dead Sept. 20 19 46

Immediate cause of death	DURATION
Internal hemorrhage (abdominal)	at once
Due to Shotgun wounds	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, Suicide, or Homicide ******* Accident Date of 9.20-46

Where did injury occur? Dan's Mountain near (City or town) Cresaptown (County) Allegany Co. (State)

Injured at home, farm, industry, public place (where?) While hunting

Means of injury Shot by another hunter

23. SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 9-20-46

Deputy Medical Examiner - Allegany Co.

DR. COWHERD

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

08642

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MRS. BERTIE JUNE KIGHT

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife KIGHT, VURL

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) DEC. 9, 1927

8. AGE: Years	Months	Days	If less than one day
18	9	5	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name SAMUEL MEYERS

FATHER 13. Birthplace MARYLAND

MOTHER 14. Maiden name ALTA ROY

MOTHER 15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept 16, 1946 (month) (day) (year)

Cemetery or crematory Rhayersville Cemetery

Location 7 Mi N Oakland

18. Funeral director Herbert C. Leighton

Address Oakland, Md.

19. Sept. 20, 1946 (Date rec'd by registrar) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 14, 1946 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 13, 1946, to Sept. 14, 1946 and that I last saw her alive on SEPT. 14, 1946

Immediate cause of death	DURATION
Shock & Hemorrage from spontaneous inversion of the uterus, following normal	2 Hrs.
Due to delivery of full term pregnancy.	
Due to Cause unknown	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Arthurs M. D. or other

Address 41 Green Street Date signed 9/19/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Dr J Norman Reeves

★ 08643 6 Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jennie Kirk

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Andrew Martin Kirk

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Dec 18 1550

8. AGE:

Years	Months	Days	If less than one day
65			...hrs. ...min.

9. Birthplace: Middlecreek - Allegany - Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER 12. Name: James Warwick

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Jane Kirk

MOTHER 15. Birthplace: Scotland

16. Informant: Martin Kirk

Address: Barton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7-16 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Mascow, Md

18. Funeral director: E S Boal

Address: Westernport Md.

19. Sept. 6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1946 at 7:00 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 1946, to Sept 4 1946

and that I last saw h...rd alive on Sept 2 1946

Immediate cause of death	DURATION
Carcinoma of Liver	4 mos.
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J Norman Reeves M.D.

M. D. or other

Address: Westernport, Md. Date signed 9-5-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

08644

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 83 years

Hospital, Institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution? 28 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 403 N. Center Street (If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Charles August Langer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 21, 1863

8. AGE: Years	Months	Days	If less than one day
83	3	6	____ hrs. ____ min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county and state)

10. Usual occupation Tin Goods Store

11. Industry or business Tin Goods

FATHER 12. Name Charles Langer

13. Birthplace Germany

MOTHER 14. Maiden name Christina M. Staunch

15. Birthplace Germany

16. Informant Mr. John Powers

Address 216 Valley St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 30 1946 (month) (day) (year)

Cemetery or crematory St. Lukes Lutheran Cemetery

Location Cumberland, Maryland.

18. Funeral director John J. Hafer

Address Cumberland, Maryland

19. Sept. 30 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-2-46 19__ to 9-27-1946

and that I last saw h[illegible] alive on 9-27-1946

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Due to Infirmities of	
Due to Age.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. J. Williams M. D. or Other

Address Cumberland Date signed 9-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

CERTIFICATE OF DEATH

08645

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, Institution, or street address where death occurred:
35 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 35 Virginia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ora Shafer Sargent

3.(b) Social Security Number 705-07-6637

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Edith M. Kline

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 13, 1886

8. AGE: Years	Months	Days	If less than one day
60	1	24	...hrs. ...min.

9. Birthplace Paw Paw, Morgan Co. W. Va.
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business B & O. Railroad.

FATHER
12. Name John R. Sargent
13. Birthplace W. Va.

MOTHER
14. Maiden name Amanda Definbaugh
15. Birthplace Town Creek, Md.

16. Informant Mrs Ora S. Sargent
Address 35 Va. Ave - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10, 1946 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept 10 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/46 19... at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/46 19... to 9/7/46 19...

and that I last saw him alive on 9/7/46 19...

Immediate cause of death	DURATION
Myocardial Failure	
Due to Bronchial Asthma	
Due to Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O. H. Williams M.D.
M. D. or other

Address Medical Bldg. Date signed 9/9/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

CERTIFICATE OF DEATH

08646 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

133 Va. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 133 Va. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Edward Lippold

3.(b) Social Security Number: 218-16-2711

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1896

8. AGE: Years: 50 | Months: 7 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: John D. Lippold

13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Margaret Cosgrove

15. Birthplace: Mt. Savage, Md.

16. Informant: Mrs. Mary Owens

Address: 133 Va. Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12, 1946 (month) (day) (year)

Cemetery or crematory: S.S. Peter & Paul

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Sept. 11, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9, 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946, to Sept. 9, 1946

and that I last saw h... alive on Sept. 6, 1946

Immediate cause of death: a. Cerebral Hemorrhage

Due to: b. Hypertension.

Due to: c.

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J. C. Duffy M. D. or other

Address: Cumberland Date signed: 9/18/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08647

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Belle Lochner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Conrad Lochner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1877 May 4

8. AGE: Years	Months	Days	If less than one day
69	6	26	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John Hamilton
13. Birthplace: Scotland
MOTHER 14. Maiden name: Mary Kilpatrick
15. Birthplace: Scotland
16. Informant: Hamilton Lochner
Address: Lonaconing
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill Cem.
Location: Lonaconing, Md.
18. Funeral director: Ellsworth S. Boal
Address: 111 Church St, Westernport, Md.
19. Oct 2 1946 (Date rec'd by registrar) J. Thurston Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1946, at 10:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1946 to Sept 30 1946 and that I last saw h.. alive on Sept 30 - 1946

Immediate cause of death	DURATION
Sudden death due to ventricular fibrillation?	
Due to: Coronary sclerosis	2 yrs.
Due to: Chronic myocarditis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Cyrle R. Everhart M.D.
M. D. or other
Address: 36 Greene St Date signed 10/1-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 Yrs
Hospital, institution, or street address where death occurred: 107 Md. Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Md. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Adelaide Delores Lynch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Lynch
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Aug. 17, 1903

8. AGE: Years: 43 Months: Days: 14 If less than one day: hrs. min.

9. Birthplace: Westernport-Allegany-Md.
(Town, county, and state)

10. Usual occupation: House-Wife

11. Industry or business

FATHER
12. Name: Patrick Morgan
13. Birthplace: Scotland

MOTHER
14. Maiden name: Catherine Wilson
15. Birthplace: Scotland

16. Informant: John Lynch
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 46 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Sept. 4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 19 46 at 12.10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 46 to Sept. 1 19 46
and that I last saw her alive on Sept. 1 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: P E Berry M. D.
M. D. or other
Address: Piedmont W. Va. Date signed: 9/2/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

Inc. 08653

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
15 So. Waverely Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 So. Waverely Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clara Elizabeth Martz

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Walter B. Martz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. I, 1882

8. AGE:

Years	Months	Days	If less than one day
63	II	I6	..... hrs. ..... min.

9. Birthplace Greensburg, Pa.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Jeremiah Beal
13. Birthplace Pa.

MOTHER
14. Maiden name Mary Cook
15. Birthplace Pa.

16. Informant Harry Martz

Address Wiley Ford, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1946 (month) (day) (year)

Cemetery or crematory Finks Glencoe Cem.

Location Glencoe Pa.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Sept. 18, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1946, at 4:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 1946, to Sept 17 1946

and that I last saw her alive on Sept 17 1946

Immediate cause of death	DURATION
Congestive Heart Failure	1 day
Cerebral Vascular Accident	3 days
Due to Hypertensive Cardio vascular disease	6 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Trevaskis, J. M.D.
M. D. or other

Address 220 Baltimore Ave Date signed 9-18-46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr Reg. Record

08649

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, Institution or street address where death occurred:
Latrobe St
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Latrobe St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Emma Richards McCormack

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Emma McCormack
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): January 14, 1872

8. AGE: Years: 74 | Months: 8 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Lonaconing - Allegany - Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

MOTHER FATHER
12. Name: Anthony Richards
13. Birthplace: Pembrokeshire Wales
MOTHER
14. Maiden name: Emma Teague
15. Birthplace: Lonaconing Md

16. Informant: Alice McCormack
Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2 1946 (month) (day) (year)
Cemetery or crematory: Laurel Hill Mem.
Location: Macon, Md

18. Funeral director: Ellsworth & Boal
Address: Westernport, Md

19. October 2 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 19 46 at 4.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 th 1946 to Sept 28 19 46
and that I last saw h alive on Sept 25 19 46

Immediate cause of death	DURATION
Uremic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ted Leese M D
M. D. or other
Address: Westernport Md Date signed: 10/3/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits: 5

Tremont Wis Ewing

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

08650

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Francis Valentine Mc Gettigan

3.(b) Social Security Number: 214-07-5475

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Minnie I. McGettigan

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): October 24, 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	10	19		

9. Birthplace: Accident, Garrett Co., Md.
(Town, county, and state)

10. Usual occupation: Dyehouse employee

11. Industry or business: Celanese Corp. of America.

FATHER 12. Name: Nelson McGettigan

FATHER 13. Birthplace: ~~Accident, Md.~~ Eckhart, Md.

MOTHER 14. Maiden name: Elizabeth Miller

MOTHER 15. Birthplace: Accident, Md.

16. Informant: Mrs. Minnie McGettigan

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16, 1946 (month) (day) (year)

Cemetery or crematory: St. Ambrose Catholic Cemetery

Location: Cresaptown, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Sept. 14, 1946 (Date rec'd by registrar) Joseph P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13, 1946, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30, 1946 to Sept 13, 1946

and that I last saw him alive on Sept 12, 1946

Immediate cause of death	DURATION
Chronic Myocarditis	3 Mos.
Due to	
Due to	
Other conditions: Cystitis and pulmonary atelectasis	

(Include pregnancy within 3 months of death)

Major findings of operation: Prostatectomy for hypertrophy prostate. Date of op. Sept 5-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. A. Tsiropulos Sr. M.D.

M. D. or other

Address: Cumberland, Md. Date signed: Sept 13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

08651

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Hours 40 Minutes
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 5 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James McKenzie

3.(b) Social Security Number: 212-12-8402

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Hannah McKenzie
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): January 23 1891

8. AGE: Years	Months	Days	If less than one day
56	7	22	...hrs. ...min.

9. Birthplace: Frostburg Maryland
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Cumberland & Westernport Bus Co

FATHER
12. Name: William McKenzie
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Marie Lawson
15. Birthplace: Durham City, England

16. Informant: Allegany Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/46 (month) (day) (year)
Cemetery or crematory: Porter Cemetery
Location: Eckhart, Md.

18. Funeral director: Joseph Durst
Address: Frostburg, Md.

19. Sept. 16, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/15 1946, at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15- 1946, to 9-15- 1946
and that I last saw h... alive on 9-15-46 19..

Immediate cause of death	DURATION
Cancer of the left lung (bronchogenic)	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Inoperable cancer left lung
Date of op. 9-
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L Wm MD
M. D. or other
Address: 59 Greene St. Date signed 9-15-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

08652

Reg. Diat. No. 7

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs.
Hospital, Institution, or street address where death occurred:
Allegany Hospital, Cumberland, Md.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Frederick Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Julia McKosky

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frank Mc Kosky
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 25, 1880

8. AGE: Years	Months	Days	If less than one day
66	0	15	____ hrs. ____ min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Wm. C. Boskey
13. Birthplace: Austria

MOTHER
14. Maiden name: Julia Boskey
15. Birthplace: Austria

16. Informant: Allegany Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/14/46 (month) (day) (year)
Cemetery or crematory: Bridgeport Cem.
Location: Brownsville Penna.

18. Funeral director: Louis Stein Inc.
Address: Cumberland Maryland.

19. Sept. 16, 1946. (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10, 1946, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6, 1945 to September 10, 1946 and that I last saw h[illegible] alive on September 10, 1946.

Immediate cause of death	DURATION
Chronic myocarditis	One year
Due to: arteriosclerosis	
Due to:	
Other conditions: Apoplectic stroke	2 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 59 Green St. Date signed: 9-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

08654

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Somerset

City or town: R.D.#1 Meyersdale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ray Alden Minick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 29, 1946

8. AGE: Years	Months	Days	If less than one day
	1	4	hrs. min.

9. Birthplace: Somerset Co. Penna.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Earl Minick

13. Birthplace: Garrett Co. Md.

MOTHER

14. Maiden name: Loverta Minick

15. Birthplace: Garrett Co. Md.

16. Informant: Mr. Earl Minick

Address: R.D.#1 Meyersdale, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5, 1946 (month) (day) (year)

Cemetery or crematory: Johnson Cem.

Location: National Pike, Garrett Co. Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Sept. 3 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3, 1946, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1946 to Sept 3- 1946 and that I last saw him alive on Sept 2nd 1946

Immediate cause of death	DURATION
Congenital Endocarditis	Since birth
Due to	
Due to: Incarcerated Rt Inguinal Hernia	3 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P. T. Owens M.D. M. D. or other

Address: Pinkerton Md Date signed: 9-3-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

08655

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 326 Pear St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Franklin Farrell Moore

3.(b) Social Security Number: 216-22-5266

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Hast
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Feb 10, 1897

8. AGE: Years	Months	Days	If less than one day
49	6	28	hrs. min.

9. Birthplace: Sugar Grove, Ohio (town, county, and state)
10. Usual occupation: Cabinet Maker-Draftsman
11. Industry or business: Woodworking Business

FATHER
12. Name: Benjamin F. Moore
13. Birthplace: Ohio

MOTHER
14. Maiden name: Cora Jackson
15. Birthplace: Cumberland Md.

16. Informant: Mrs F. F. Moore
Address: 326 Pear St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11, 1946 (month) (day) (year)
Cemetery or crematory: Greenmont Cemetery
Location: Cumberland, Md.

18. Funeral director: John J. Fuller
Address: Cumberland Md.

19. Sept. 10, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/8/46, 19..., at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3, 1946 to Sept 8, 1946 and that I last saw h... alive on Sept 8, 1946.

Immediate cause of death	DURATION
perforation of Gastric Ulcer	
Due to	
Due to	
Other conditions: peritonitis due to ulcer perforation	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: perforation of pylorus
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: D. Lee Do M. D. or other
Address: 122 Bedford St Date signed: 9/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

08656

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days.

Hospital, institution, or street address where death occurred: La Vale. Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Franklin St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Lloyd W. Myers

3. (b) Social Security Number None.

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of husband or wife: Frances Brookman

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., dsy, yr.): Jan 27 1857.

8. AGE: Years 89 | Months 7 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Steelworker

11. Industry or businss: Retired 20 yrs.

FATHER
12. Name: Davis Myers
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Connors
15. Birthplace: Cumberland Md.

16. Informant: Mrs. Kneisley

Address: Cumberland.

17. Burial, cremation, or removal. Which? Burial Date thereof: Sept 28 46 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Sept 28, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1946 at 4 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25, 46 19 to Sept 25, 46 19 and that I last saw him alive on Sept 25, 1946 19

Immediate cause of death	DURATION
Myocardial failure	
Chronic Myocarditis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. H. Williams, M.D. M. D. or other

Address: Date signed 9-26-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08638

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Hours
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 8 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Baby Girl Nogle

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1946

8. AGE: Years | Months | Days | If less than one day: 8 hrs. ..... min.

9. Birthplace: Cumberland, Alleg. Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: John Frederick Nogle
13. Birthplace: Bedford, Pa.

MOTHER
14. Maiden name: Edna Irene Sharpless
15. Birthplace: Vindex, Md.

16. Informant: J.F. Nogle
Address: Kitzmiller, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1946 (month) (day) (year)
Cemetery or crematory: Hamill Cemetery
Location: Kitzmiller, Md.

18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.

19. Sept. 9 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1946, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8 1946 to September 8 1946 and that I last saw h... alive on September 8 1946.

	DURATION
Immediate cause of death: premature baby (7 month)	8 hrs
Due to: Toxic pregnancy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. Blaine M.D. (M. D. or other)
Address: 59 Green St. Date signed 9-10-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

L. Pump

Within corporate limits ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08657

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
436 Laing Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 436 Laing Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harriet E. Norris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Geo. W. Norris
6.(c) If alive, give age years

7. Birth date of deceased (mo., dy., yr.) April 3, 1876

8. AGE: Years	Months	Days	If less than one day
70	5	7	hrs. min.

9. Birthplace Little Orleans Maryland
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Henry Apple
13. Birthplace Maryland

MOTHER
14. Maiden name Hannah Linaburg
15. Birthplace Maryland

16. Informant Robert Norris
Address 436 Laing Ave.

17. Burial Date thereof Sept. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hillcrest
Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland Md.

19. Sept 11, 1946. Joseph C. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10, 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10, 1946 to Sept 10, 1946
and that I last saw h[illegible] alive on Sept. 10 1946

Immediate cause of death	DURATION
Coronary Thrombosis	10 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clay F. Jewett M. D. or other
Address Cumberland, Date signed 9/10/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08659

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 yrs.

Hospital, institution, or street address where death occurred: Route 2 Bloomlove Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City: Near Cumberland - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 2 [redacted], Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Clara Elizabeth Odgers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. H. Odgers

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Aug 17, 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	0	25		

8. Birthplace: Frostburg Allegany Co. Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: Conrad Pfaff
13. Birthplace: Unknown

MOTHER
14. Maiden name: Jennie C. During
15. Birthplace: Ohio

16. Informant: Mrs Howard Feagles

Address: Route 2 - Flintstone Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14, 1946 (month) (day) (year)

Cemetery or crematory: Prosperity Methodist Cem.

Location: Near Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Sept. 14 1946 (Date rec'd by registrar) Joseph D. Dunkle, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11, 1946, to Sept. 12, 1946

and that I last saw her alive on Sept. 11, 1946

Immediate cause of death	DURATION
Coronary Thrombosis (3 days)	
Cerebral Hemorrhage, Sept. 12-46	
Due to: Right Hemiplegia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dwight L. Furrer M.D. or other

Address: Cumberland Date signed: 9/13/46

Within co. porate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 08660

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 mo.
Hospital, institution, or street address where death occurred: 538 N. Mechanic St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 538 N. Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Barbara Henrietta Ollrick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William F. Ollrick
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 10, 1887

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	1	18		

9. Birthplace: Cumberland, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER — 12. Name: Geo. Baker
FATHER — 13. Birthplace: Germany
MOTHER — 14. Maiden name: Mary Stiefler
MOTHER — 15. Birthplace: Germany
16. Informant: Mrs. Blaine D. Ellicott
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30, 1946 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: Louis Stein Sons
Address: Cumberland, Md.
19. Sept. 28, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28, 1946, at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17, 1946, to Sept 28, 1946, and that I last saw her alive on Sept 27, 1946
Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 days
Due to: Arterial hypertension — DURATION: 6 mos
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. A. Trewaskis, Jr., M.D. (M. D. or other)
Address: Cumberland, Md. Date signed: Sept 28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

CERTIFICATE OF DEATH

08661 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks 6 days

Hospital, institution, or street address where death occurred: Miners' Hospital

How long in hospital or institution? 2 weeks 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: O'Mara Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Hugh L. O'Rourke

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If elive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 8, 1873

8. AGE:

Years	Months	Days	If less than one day
73	5	12	...hrs. ...min.

9. Birthplace: Ocean Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Coal Mining

11. Industry or business: Ocean Mine

FATHER
12. Name: Patrick O'Rourke
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Anne Cavanaugh
15. Birthplace: Ireland

16. Informant: Mrs. John A. Malloy

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23 1946 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

16. Funeral director: M. Erchhorn

Address: Lonaconing, Md.

19. 9-22 19 46 (Date rec'd by registrar) Mrs. Harvey N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 19 46, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 19 46 to 9/20 19 46 and that I last saw him alive on 9/20 19 46

Immediate cause of death	DURATION
Pulmonary Embolism	5 min.
Due to: Fracture of hip	20 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.: ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 9/1/46

Where did injury occur? Midland Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell at home Injured at work? No

23. SIGNATURE: Hilda Jane Welty M.D.
M.D. or other

Address: Frostburg Date signed: 9/20/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

08662

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, Institution, or street address where death occurred:
112 Pennsylvania Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence W. Owens

3.(b) Social Security Number 705-05-5302

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret Waltz Owens

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) April 20, 1898

8. AGE: Years	Months	Days	If less than one day
48	5	4	...hrs. ...min.

9. Birthplace Somerset Co. Pa.
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business B & O R R

FATHER
12. Name Oliver Owens
13. Birthplace Pa.

MOTHER
14. Maiden name Jennie Trautman
15. Birthplace Pa.

16. Informant Mrs. Margaret Owens

Address 112 Pennsylvania Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26, 1946 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept 26, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 24 1946 and that I last saw h... alive on Sept 24 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Coronary sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. Williams M.D. M. D. or other

Address Medical Bldg. Date signed 9/24/46.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

08663

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 Years

Hospital, institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 3 Years 6 Mo 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Polk St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Alice Pennington

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 17, 1873

8. AGE: Years	Months	Days	If less than one day
73	8	7	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Worker Salvatation Army

11. Industry or business: Salvatation Army

FATHER
12. Name: John Whitehead
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Miss Rose O'Neil
Address: 2816. Harlem Ave, Baltimore 16, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/26/46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

16. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 26, 1946 (Date rec'd by registrar) J. C. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 19 46 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3.12. 1943 to 9.24. 1946 and that I last saw h er alive on 9.21. 1946

	DURATION
Immediate cause of death: Broncho Pneumonia	
Due to: Chronic Bronchitis	
Due to: Infirmities of Age.	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. F. Williams M. D. or Other

Address: Cumberland Md. Date signed: 9.24.46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

Jan Amer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08664

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred: 804 Washington st

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 804 Washington st
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas N. Peters

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Susannah A. Peters

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1884

8. AGE:

Years	Months	Days	If less than one day
61	10	6	..... hrs. ..... min.

9. Birthplace Dublin Md.
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Candy Business

FATHER 12. Name Travilla E. Peters

13. Birthplace Md.

MOTHER 14. Maiden name Flora Windsor

15. Birthplace Md

16. Informant Mrs. Thomas A. Peters

Address Cumberland, Md.

17. Burial Date thereof Sept. 8 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Sept. 7 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1946, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 Sept 1946, to 5 Sept. 1946

and that I last saw h.. alive on 4 Sept 1946

Immediate cause of death Chronic nephritis with hypertension

DURATION

Due to Hypertension - Heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Orsdale
M. D. or other

Address 110 S. Centre St. Date signed 10 Sept 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

08665

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49. Years

Hospital, Institution, or street address where death occurred:
11. Browning St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11. Browning St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ella S. Ranck

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jay D. Ranck

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 22 1866

8. AGE: Years	Months	Days	If less than one day
80	2	21	..... hrs. ..... min.

9. Birthplace: Franklin Mills, Fulton Co, Penna
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: William H. Downs
13. Birthplace: McConnelsburg, Pa.

MOTHER
14. Maiden name: Elizabeth Chisholm
15. Birthplace: Perry County, Penna

16. Informant: Jay D. Ranck

Address: 11. Browning St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/46 (month) (day) (year)

Cemetery or crematory: Warfordsburg Presbyterian Cem

Location: Warfordsburg, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 17 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1946, at 11 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 6 1946, to Sept 16 1946 and that I last saw h[illegible] alive on Sept 16 1946

Immediate cause of death	DURATION
Chronic Myocarditis	1944
Chronic N.E. Nephritis	1945
Due to Arteriosclerosis	1940
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. P. Franklin M.D. M. D. or other

Address 26 West Cumberland Md. Date signed 9/16/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 08666 8 Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: Douglas Avenue
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No.: Douglas Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: John D. Robertson

3.(b) Social Security Number: 219-01-4819

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amelia Walker Robertson
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 28, 1861

8. AGE: Years: 85 | Months: 4 | Days: 27 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business: Georges Creek Coal Co.

FATHER
12. Name: David Robertson
13. Birthplace: Nova Scotia

MOTHER
14. Maiden name: Jessie Gordon
15. Birthplace: Nova Scotia

16. Informant: Mrs. Charlotte Gleason
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: W. Eichhorn
Address: Lonaconing, Md.

19. Sept 27 1946 (Date rec'd by registrar) Jennette M. Pool Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1946, at 8:10 A. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1946, to Sept. 25 1946
and that I last saw him alive on Sept 25 1946

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work? /

23. SIGNATURE: Henry D. Hodgson M.D. M. D. or other
Address: Lonaconing, Md. Date signed: Sept. 26 '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

08667 9
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Mt. Savage, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Clabaugh
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kenneth Lee ~~Baby Boy~~ Robertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 46

8. AGE: Years | Months | Days | If less than one day 11 hrs. min.

9. Birthplace Frostburg Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Leroy Robertson
13. Birthplace Allegany, Md.

MOTHER 14. Maiden name Ethel Bowman
15. Birthplace Mount Savage, Md.

16. Informant Mrs. Leroy Robertson
Address Clabaugh, Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-26-1946 (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Mt. Savage, Md.

18. Funeral director Jacob Baker
Address Frostburg, Md.

19. 9-26 1946 Miss Stanley N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946, at 1:30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 1946, to Sept 24 1946

aed that I last saw h[illegible] alive on Sept 24 1946

Immediate cause of death	DURATION
Premature Twin baby Blue	
Due to Probable Heart condition Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Allen G. Mooney Md
M.D. or other
Address Cumberland Md Date signed 9-26-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

08668

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 yrs

Hospital, institution, or street address where death occurred:
816 Buckingham Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 816 Buckingham Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Morris Rosenbaum

3.(b) Social Security Number 217-03-3509

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Esther Bamberger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5 1880

8. AGE: Years	Months	Days	If less than one day
66	2	25	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Husband

11. Industry or business Department Store

FATHER 12. Name Simon Rosenbaum

13. Birthplace Germany

MOTHER 14. Maiden name Rika Nathan

15. Birthplace Baltimore Md.

16. Informant Simon Rosenbaum II

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 '46 (month) (day) (year)

Cemetery or crematory East View Cem.

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland.

19. Oct. 1 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1946 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1946 to Sept 30 1946 and that I last saw him alive on September 30 1946

Immediate cause of death	DURATION
Acute Myocardial Failure	10 min.
Due to Myocardial Disease	10 yrs.
Due to Coronary Artery dis.	10 yrs.
Due to	
Other conditions Cerebral Embolus (left)	8 days.
C. paralysis right side	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M. D. or other

Address 15 E Liberty St Date signed 9/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

08669

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
1101 Oldtown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1101 E. Oldtown Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph L. Rowley

3.(b) Social Security Number 705-05-4824

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Annie V. Fisher
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 4 1884

8. AGE: Years	Months	Days	If less than one day
62	6	4	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual occupation Machinest
11. Industry or business B & O R.R. Co.
FATHER 12. Name Richard Rowley
13. Birthplace England
MOTHER 14. Maiden name Jane Brown
15. Birthplace England
16. Informant Mrs Annie V. Rowley
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 11, 1946 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.
18. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19. Sept. 10 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 19 46, at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on Dead Sept. 8 19 46

Immediate cause of death	DURATION
Coronery occlusion	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M. D. or
Address 125 Baltimore St Date signed 9-9-1946
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08670

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 102 Genna Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Genna Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Lena Savilishi

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John M. Savilishi

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): April 27, 1873

8. AGE: Years: 73 Months: 4 Days: 24 If less than one day: ....hrs. ....min.

9. Birthplace: Clarysville Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Wm. Mines

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary C. Diehl

15. Birthplace: Germany

16. Informant: Edward J. Savilishi

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/46 (month) (day) (year)

Cemetery or crematory: St. Patrick Cem.

Location: Furnace Street

18. Funeral director: Lewis Stein Inc.

Address: 117 Frederick St

19. Sept. 23, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1946, at 11:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1946, to Sept 21 1946

and that I last saw her alive on Sept 21 1946

Immediate cause of death	DURATION
Cerebral-Apoplexy	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. B. Mathews M. D. M. D. or other

Address: 49 Greene St Date signed: 9-23-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

08671

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hosp.
How long in hospital or institution? One half hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 531 Pearre Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Perry J. Shipley

3.(b) Social Security Number: 705-05-8138

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Scott
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb 20 1880

8. AGE:

Years	Months	Days	If less than one day
66	7	2	hrs. ... min.

9. Birthplace: Orleans Cross Rd. W.Va. (Town, county, and state)
10. Usual occupation: Train Dispatcher
11. Industry or business: B & O R.R.

FATHER
12. Name: John Shipley
13. Birthplace: West Va.

MOTHER
14. Maiden name: Nancy Lawson.
15. Birthplace: West Va.

16. Informant: Mrs. Leo Wilson
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/46 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Balto. Pike.

18. Funeral director: Louis Stein, Inc.
Address: 47 Frederick Street

19. Sept. 23 46. (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-22-1946 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-20-1946 to 9-22-1946 and that I last saw him alive on 9-17-1946

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: T. J. Williams M. D. or other
Address: Cumberland Md. Date signed 9-23-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

Within corporate limits

DR WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47(c)

CERTIFICATE OF DEATH

08672

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County Grant
City or town WILSON W.VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ROBERT C. SHUMAKER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife OTTIE MOUSE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 25, 1886

8. AGE: Years	Months	Days	If less than one day
59	11	2	hrs. ..... min.

9. Birthplace WILSON, GRANT, West Virginia
(Town, county, and state)
10. Usual occupation MERCHANT
11. Industry or business

FATHER
12. Name JOHN T. SHUMAKER
13. Birthplace W. VA.

MOTHER
14. Maiden name MARY JACK
15. Birthplace VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 29 Sept 46 (month) (day) (year)
Cemetery or crematory Bayard
Location Bayard, W. Va.
18. Funeral director Ellsworth S. Boal
Address 111 Church St. Westernport, Md.
19. Sept. 27, 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 27 19 46 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16 19 46 to Sept. 27 19 46 and that I last saw him alive on Sept. 26 19 46

Immediate cause of death	DURATION
Bronchogenic Carcinoma	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results Refused Dec'd ok

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 9-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

08673

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland M.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown.

Hospital, Institution, or street address where death occurred:
Allegany Hosp.

How long in hospital or institution? Seven da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Winchester Rd
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Joseph Thomas Simpson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Susannah Nelson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29 1869

8. AGE: Years	Months	Days	If less than one day
77	3	11	..... hrs. ..... min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Celanese Corp.

11. Industry or business

FATHER
12. Name: Jos. T. Simpson
13. Birthplace: England.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Ethel Robertson.
Address: Cresaptown

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/13/46 (month) (day) (year)

Cemetery or crematory: St. George

Location: Mt Savage

18. Funeral director: Lewis Stein Inc.
Address: Cumberland Md

19. Sept. 12 1946 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 Sept 1946, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Sept 1946, to 10 Sept 1946 and that I last saw h.im alive on 10 Sept 1946

Immediate cause of death	DURATION
Anemia, due to hemorrhage	1 wk.
from esophageal varices	
Due to Carcinoma of liver,	?
secondary to carcinoma elsewhere	
Due to Primary site of cancer Unknown cause	
Extensive arteriosclerotic heart disease	10 y
Other conditions Paget's Disease	?
nephrolithiasis, left	?

(Include pregnancy within 3 months of death)

Major findings of operations: nephrolithiasis

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howell E. Wesson, MD
M. D. or other

Address: Cresaptown, Md Date signed: 11 Sept 46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 10674

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany Hospital, Cumberland, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Virginia County: Mineral

City or town: Ridgeley
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Helena
Miss Annie Snyder

3.(b) Social Security Number 213-22-3619

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/8/06

8. AGE: Years 40 | Months 0 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: West Virginia, Ridgeley, Mineral
(Town, county, and state)

10. Usual occupation

11. Industry or business: Celanese Corp.

FATHER 12. Name: Charles Andrew Snyder

13. Birthplace: Adams County, Penna.

MOTHER 14. Maiden name: Mary Jane Herrick

15. Birthplace: Mineral County, W. Va.

16. Informant: Allegany Hospital

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1946 (month) (day) (year)

Cemetery or crematory: St. Ambrose

Location: Cresaptown, Md.

18. Funeral director: N. L. Rogers

Address: Keyser, W. Va.

19. Sept. 19 1946 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1946 at 4:38 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14th 1946, to Sept. 15 1946 and that I last saw h.e.r alive on Sept. 17th 1946.

Immediate cause of death	DURATION
Cardiac Dilatation	3
Coronary Thrombosis	3
Due to	
Due to	
Other conditions: Cholecystectomy	9-16-46

(Include pregnancy within 3 months of death)

Major findings of operations: Gall bladder full of stones. Date of op. Sept. 16th

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: James E. McLean M. D. M. D. or other

Address: 99 Greene St. Date signed: 9-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55

CERTIFICATE OF DEATH

08675

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 423 VIRGINIA AVE. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MRS. PAULINE SPIGELMYER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SEPARATED

6.(b) Name of husband or wife JAMES SPIGELMYER (SEPARATED) 6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) SEPT. 4, 1911

8. AGE: Years	Months	Days	If less than one day
35	0	26	...hrs. ...min.

9. Birthplace PENNA. (Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

FATHER 12. Name AIDE THOMAS

13. Birthplace PENNA.

MOTHER 14. Maiden name AGNES PFIESTER

15. Birthplace PENNA.

16. Informant [signature] Address Confidential - Ed

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3, 1946 (month) (day) (year)

Cemetery or crematory Coalport Cem

Location Coalport, Penna.

18. Funeral director H. D. Durst

Address Cumberland Md.

19. Sept. 30, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 30, 1946 at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 1946 to 30 Sept 1946 and that I last saw h... alive on 30 Sept 46

Immediate cause of death	DURATION
Generalized Carcinomatosis	1 yr
Due to (Unknown Origin this date)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Generalized Carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fuller B. Whitworth M. D. or other

Address 112 Bedford St Date signed 30 Sept 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08676

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Oldtown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life 25 yrs.

Hospital, Institution, or street address where death occurred: Oldtown Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Naomi L. Steckman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: Eugene E.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 30, 1871

8. AGE:

Years	Months	Days	If less than one day
75	8	5	..... hrs. ..... min.

9. Birthplace: Hancock Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Ignatius Roby

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Owens

MOTHER — 15. Birthplace: Md.

16. Informant: Eugene E. Steckman

Address: Oldtown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 7, 1946 (month) (day) (year)

Cemetery or crematory: Oldtown Cem.

Location: Oldtown, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Sept 7 1946 (Date rec'd by registrar) Mrs L. A. Shawhold Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1946, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to Sept 5 1946

and that I last saw h[illegible] alive on Sept 2 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 yrs.
Due to Arterio Sclerosis	about 3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. E. Owens M.D. M. D. or other

Address: 133 Va Ave Date signed: 9/10/46

Within corporate limits

W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08677

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State West Virginia County MIneral
City or town Piedmont (If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Forcas Street (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Sullivan, Charles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife Anna May Henry
6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 9-15-1909

8. AGE:	Years	Months	Days	If less than one day
	36	11	21	....hrs. ....min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual occupation Electrician
11. Industry or business West Virginia Pulp & Paper Co.

FATHER
12. Name Sullivan, William 6
13. Birthplace Unknown

MOTHER
14. Maiden name Adams, Cora
15. Birthplace Unknown

16. Informant Memorial Hospital
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1946 (month) (day) (year)
Cemetery or crematory Rhulos Cem.
Location Westernport, Md.
18. Funeral director Oldsmobile & Buick
Address Westernport, Md.

19. Sept. 9 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946 at 9:00p

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug. 7 1946 to Sept 6 1946 and that I last saw ...alive on Aug. Sept 6 1946

	DURATION
Immediate cause of death Uremic Nephritis	?
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D.
Address Cumberland Date signed 9-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

08678

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Gilmore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Gilmore

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Don Ellsworth Tipton

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: — (Infant)

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1946

8. AGE: Years	Months	Days	If less than one day
2 weeks	—	—	...hrs. ...min.

9. Birthplace: Miners Hospital, Frostburg, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: Ellis Tipton

FATHER — 13. Birthplace: Gilmore Md

MOTHER — 14. Maiden name: Margaret Matthews

MOTHER — 15. Birthplace: Lonaconing, Md

16. Informant: Ellsworth Tipton

Address: Gilmore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1946 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonaconing, Md

18. Funeral director: J. L. Eichhorn

Address: Lonaconing, Md

19. Oct 1 1946 (Date rec'd by registrar) Jeanette M Beal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 19 46 at about 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dead Sept 30 1946

Immediate cause of death: Prematurity — DURATION: —

Due to: — —

Due to: — —

Other conditions: Atelectasis (bi-lateral) & Broncho Pneumonia — 2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md Date signed 9/30/46

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B)

CERTIFICATE OF DEATH

E-X 08679

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred: 504 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Marion St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rachel D. Twigg

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife Alonzo V. Twigg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21, 1876

8. AGE: Years	Months	Days	If less than one day
70	5	25	..... hrs. ..... min.

9. Birthplace Artemas, Bedford Co., Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Joseph Smith

13. Birthplace Pa.

MOTHER 14. Maiden name Barbara Cavender

15. Birthplace Pa.

16. Informant Mrs. Louis Hart

Address 700 Frederick St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 19, 1946 (month) (day) (year)

Cemetery or crematory Greenmount Cemetary

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 19 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1946, to Sept. 16 1946 and that I last saw h alive on Sept 16 1946

Immediate cause of death Obstructing carcinoma at the pyloric end of stomach — DURATION about 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 9-17-46

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 9 — 018680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 135 Washington

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Hoffman Watson

3.(b) Social Security Number: 213-09-6598

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mary Jane Watson

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): April 4 — 1881

8. AGE: Years: 65 Months: 5 Days: 5 If less than one day: ....hrs. ....min.

9. Birthplace: Eckhart-alleg-md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Coal mine

FATHER — 12. Name: John H. Watson

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Sarah Close

MOTHER — 15. Birthplace: Scotland

16. Informant: Hugh Watson

Address: Frostburg, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11-1946 (month) (day) (year)

Cemetery or crematory: E Eckhart

Location: E Eckhart, md

18. Funeral director: J. J. Durst

Address: Frostburg, md

19. 9-10 1946 (Date rec'd by registrar) Mrs. Mary V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 19 46, to Sept 9 19 46 and that I last saw him alive on Sept 7 19 46.

	DURATION
Immediate cause of death: Chronic Myocarditis	2 yr
Due to:	?
Due to: Hypertension	2 yr
Other conditions	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W O M Lane M.D. M. D. or other

Address: Frostburg Md Date signed: 9-10-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

08681

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Elizabeth Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Edwin Isaac Williams

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct. 1 - [illegible] 1874

8. AGE:

Years	Months	Days	If less than one day
71	11	4	..... hrs. ..... min.

9. Birthplace Keyser W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jos. Williams
13. Birthplace Frostburg Md.

MOTHER
14. Maiden name Virginia Pelham
15. Birthplace Keyser W. Va.

16. Informant Edwin I. Williams

Address Eckhart Mines Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept - 8 - 1946 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg Md.

18. Funeral director Jacob G. Rafe

Address Frostburg, Md.

19. 9-10 1946 Mrs. Nancy V. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1946, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to Sept 5 1946

and that I last saw her alive on Sept 1946

Immediate cause of death	DURATION
Chronic Myocarditis	1 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. O. McConeghy M.D.
M. D. or other

Address Frostburg Md. Date signed 9-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M